

TEMPORARY SHELTER CARE / GROUP HOME AGREEMENT

Use of form: Use of this form is voluntary, however, the information must be provided. Personally identifiable information is collected for identification purposes only and will not be used for any other purpose.

Instructions: It is important that you carefully read the information below and provide the requested information. If you have any questions after doing so, your Worker will be able to address them. Provide the required signatures on page 2.

We / I do authorize the Agency to place our / my child in: ☐ a Temporary Shelter Care Facility
☐ a Licensed Group Home

Child's name: _____ Child's birthdate: _____
(Last, First, MI) (mm / dd / yyyy)

THIS PLACEMENT AGREEMENT IS TIME LIMITED. Check the box below that indicates the placement time period.

☐ Limited to 20 days (runaway) ☐ Limited to 15 days (non-runaway group home only)

Agreement begins: _____ Agreement ends: _____
(mm / dd / yyyy) (mm / dd / yyyy)

- We / I consent to the release of any information between the Agency and / or the _____ School District(s).
- We / I consent to let our / my child go swimming while under the supervision of public school personnel or volunteers.
- We / I consent to let our / my child go on any mode of transportation arranged by the public schools and attend recreational activities while under the supervision of public school personnel or volunteers.
- We / I consent to let our / my child use certain personal belongings, such as clothing, and we / I understand that the Agency and the public schools will not be responsible for any damage or loss.
- We / I consent to let our / my child attend religious services.
- We / I request that our / my child _____ be evaluated by a multidisciplinary team. It is our / my understanding that we / I will be notified, allowed to participate, and these results will be shared with us / me.
- We / I agree to accept the medical, dental and surgical treatment arranged for our / my child by the Agency. We / I understand that we / I will be notified by the Agency in the event of serious illness. In the event that we / I cannot be reached, we / I hereby authorize the Director of the Agency or his / her designee to consent to and provide for surgery in emergency cases.
- We / I ☐ do ☐ do not have health insurance which covers our / my child.

If you do have health insurance covering the child, provide:

Name of insurance company: _____

Insurance policy number: _____

- We / I hereby agree to reimburse the Agency regularly for the care of our / my child in the amount of \$_____ per ☐ month ☐ week beginning _____. Payments are to be made to _____.
- We / I agree to keep the Department informed of any changes in our / my circumstances, such as address, telephone number, employment and earnings, marital status, health and plans regarding the child.

The custodial parent or child age 12 or older can terminate this agreement by notifying the Worker currently servicing the family (or his / her supervisor) in at least 48 hours. The Agency Worker can terminate this agreement by notifying the parent and child age 12 or older.

PROVIDE SIGNATURES ON PAGE 2

SIGNATURE - Mother

Date Signed

()

Full Address - Mother

Telephone Number

SIGNATURE - Father

Date Signed

()

Full Address - Father

Telephone Number

SIGNATURE - Guardian

Date Signed

()

Full Address - Guardian

Telephone Number

SIGNATURE - Child (12 years of age or older)

Date Signed

()

Full Address - Child

Telephone Number

SIGNATURE - Worker

Date Signed

()

Work Address

Telephone Number

Original: Shelter / Group Home
Copies: File
Parent
Guardian
Child